

Division of Health Care Facilities

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>TN9011</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN</b><br>B. WING _____  |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/30/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHRISTIAN CARE CENTER OF JOHNSON CITY</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>140 TECHNOLOGY LANE</b><br><b>JOHNSON CITY, TN 37604</b>                     |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE   |
| N 000  | Initial Comments<br><br>Entity reported complaint investigation #<br>TN00029167 was completed on January 30,<br>2012. The allegations were substantiated and no<br>deficiencies were cited under chapter 1200-8-6,<br>Standards for Nursing Homes. | N 000  |  |  |  |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

22D421

If continuation sheet 1 of 1